

Netherlands Health Care System

The new health insurance legislation integrates the former statutory sickness fund scheme that covered about 63% of the population and private health insurance covering the remaining 37% into a single mandatory scheme. Legislation obliges all residents to purchase a basic health plan, but leaves them free to choose their insurer and type of plan. To encourage competition, all residents are permitted to switch to another insurer by the end of each year. Insurers, which may operate for-profit, are expected to compete on premium rates, type of health plan (e.g. a plan with a deductible, a preferred provider network or specific service level agreements). By means of sophisticated risk equalization scheme the government intends to safeguard a common level playing field for competition and avoid preferred risk selection. Some parameters in this scheme even make it attractive to develop health plans geared to the needs of specific categories of people with chronic illnesses (e.g. diabetes and COPD).

Legislation contains various regulations to guarantee the social character of the new scheme that, formally speaking, is a private arrangement. To guarantee access to health care and preserve risk solidarity in financing, insurers must accept each applicant and are not permitted to vary their premium rates according to age, sex or pre-existing medical disorders. Another “public constraint” concerns the standard package of health services established by the government. The latter constraint plus the obligation to purchase a basic health plan sets limits to consumer choice in health insurance. To preserve income solidarity the government pays persons on low income an income-adjusted cash benefit to make the purchase of a health plan financially affordable for them.

The new health insurance legislation only regulates the basic health plan. It does not contain regulations on complementary health plans. Consumers are free to take out a complementary plan for health services not covered by their basic plan (e.g. dental care for adults and physiotherapy). Health insurers are free to develop complementary plans and set restrictions to access.